	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	COI	ATE SURVEY MPLETED 116/2013
	PROVIDER OR SUPPLIEI			300 W 5	ddress, city, state, zi 33RD AVE N 46410	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
VV000000			W0	00000			
	revisit to the inv	or the post certification restigation of complaint onducted on March 15,					
	Complaint #IN0	0123154: Corrected.					
	Unrelated defici	encies: Not Corrected.					
	Dates of survey: 2013.	May 7, 8, 9, 10 and 16,					
	Facility number Provider numbe AIM number: 10	r: 15G040					
	Surveyor: Christine Colon	, QIDP					
	state findings in 9.	eficiencies also reflect accordance with 460 IAC mpleted 5/21/13 by Ruth					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000597

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE COMPL 05/16/	ETED
	ROVIDER OR SUPPLIER NORTHWEST INDI			300 W	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000104		DY dy must exercise general d operating direction over	W0	00104	Methods for monitoring diabetes, notifying physicians, and filing nursing assessment have been modified. Please refer to tags W14 W331, and W336.	9,	05/30/2013
	facility's governi operating direction of 2 sampled clied oversight of the state of	review and interview, the ng body failed to exercise on over the facility for 1 ents (client A), to provide facility's nursing services of client A in regard to lient's healthcare needs, eitten policy and a plan specific to meet the care needs of client A.					
	body failed to ex over the facility to policy and proce body neglected to	T149. The governing ercise operating direction to implement written dures. The governing or ensure nursing services are needs of client A.					
	body failed to ex operating direction	7331. The governing ercise general policy and on over the facility to y's nursing services met					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PDMX12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		A. BUII	LDING	00	COMPL 05/16/	ETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/.0/		
NAME OF P	ROVIDER OR SUPPLIER				53RD AVE			
	NORTHWEST INDI		GARY, IN 46410					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
TAG		care needs in regard to		IAG	BEIGEROT		DATE	
		C						
		lient A's health needs and						
	developing a risk plan specific to meet the health care needs of client A.							
	nearth care needs	s of client A.						
	This deficiency v	was cited on 3/15/13.						
	The facility failed to implement a							
		correction to prevent						
	recurrence.	correction to prevent						
	recurrence.							
	9-3-1(a)							

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Event ID: PDMX12

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/16/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG W000149	· ·	TAG W000149	CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY) Client A's physician was notified of the low readings on 4/30/13, 5/6/13, and 5/28/13. Client A's risk plan will be revised to reflect physician recommendations by the team to ensure measures put in place are still appropriate by 6/15/13. The IDT team will review all risk plans for all clients to determine if any changes need to be made. The Community Services Nurse will ther train staff on any changes as applicable.	DATE 06/15/2013
	Order indicated staff are to contact her physician when blood glucose readings are below 80 and over 300. -Nursing notation dated 4/22/13: "I was			
	called to workshop because [client A]'s blood sugar was low. Upon arrival I found her to be alert and oriented to the situation. [Health Safety Tech name] (HST) was having her take sips of pop. [Client A] said [HST name] was helping her out with her blood sugar. [Client A] had no complaints of dizziness. She was			

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Event ID: PDMX12

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G040	B. WIN	G		05/16/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					S3RD AVE		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		my. [Client A] stated					
		ne was fine. Blood sugar					
	tested at 61 and was allowed to leave						
	HST office. [Client A] then sat at a table						
	and pulled out a jello and began to eat."						
	No further documentation was submitted						
	for review to indicate client A's physician						
	was contacted in						
	notation.						
	-Nursing notation dated 5/6/13:						
	"Workshop repo	rted abnormal behaviors,					
	confusion noted.	BS (blood sugar) at					
	11:20 was 20. N	lurse at workshop					
		ving client a soda pop at					
		ontacted [Doctor name]					
		. BS reading at 11:50					
		's (Emergency Medical					
		transport to ER, resident					
	· ·	sident aware of place,					
		o confusion noted.					
		Professional (DSP) at					
		ructed to monitor BS					
	1	0, 52 juice given. At					
	•	A.M., before Amaryl 2 mg					
	`	BS read at 97. At					
	_	M 208, MD notified. BS					
		O orders to discontinue					
	` `	edtime). Will continue to					
	monitor."						
	An interview wi						
		ctor (BHCD) was					
	conducted on 5/1	10/13 at 4:45 P.M The					

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PRINTED: 06/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE : COMPL	
11112 12111	or confidence.	15G040		LDING		05/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		the agency was working		TAG	Dia tellite 1		DATE
		A's lack of healthcare					
	oversight for client A's health care needs.						
	_	cated client A did not					
	have documented monitoring of her						
	health care status.						
	A review of the	facility's "Policy for					
	Handling Cases	of Neglect and Abuse"					
		vas completed at the					
	facility's administrative office on 5/10/13						
	at 3:30 P.M., and indicated: "In order to						
		al welfare of the clients,					
		Indiana has in effect the					
		with regard to abuse,					
		tation of clients by					
		ohibits all abuse, neglect of our clientsStaff will					
	•	ort any allegations of					
		exploitation of our					
	clients per agenc	•					
	procedureNegl						
	-	ng a client in a situation					
		at to his/her health and					
	well beingExai	mples include, but are not					
	limited to, depriv	ving a client of food,					
	clothing, shelter	or medical care."					
	This is Color	:4-1 2/15/12					
	_	was cited on 3/15/13. d to implement a					
	1	correction to prevent					
	recurrence.	correction to prevent					
	rocurrence.						
	9-3-2(a)						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040			00	COM 05/1	TE SURVEY TPLETED 16/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		

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Event ID: PDMX12

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Facility ID: 000597

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G040	B. WIN			05/16/2013
			Б. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				53RD AVE	
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W000331	483.460(c)					
	NURSING SERV					
		provide clients with nursing				
	services in accordance with their needs.			00221		06/15/0010
			WO	00331	Staff will fax in the MAR daily s	so 06/15/2013
		ew and record review, for			that the Community Services Nurse can review Client A's ble	ood .
	1 of 2 sampled c	lients (client A), the			sugar readings on a daily basis	
	facility's nursing	services failed to meet			6/15/13. The Community Servi	
	the needs of the	client in regard to			Nurse will review these blood	
		lient's health needs and			sugars and make contact with	
		x plan specific to meet the			Client A's physician as necess	ary.
	health care needs				In the event an MAR is not	
	meanin care needs	S OI CHEIR A.			received, the Community	
					Services Nurse will contact the	
	Findings include	:			Area Manager to follow up with staff. Additionally a Journal wil	
					implemented by 6/15/13 which	i i
	A review of clien				to include blood sugar reading	
	conducted at the	facility's administrative			and interventions, intake and	- '
	office on 5/8/13	at 3:30 P.M Review of			applicable behavioral	
	client A's medica	al record indicated the			observations. The Community	
	following:				Services Nurse will review this	
	J				journal weekly. The Director of	i i
	A review of clien	nt A's 5/1/13 Physicians			Health Services will monitor the nursing staff is receiving the	
		staff are to contact her			information in a timely manner	i i
		plood glucose readings			through weekly audits of the	
	are below 80 and				information for three months a	nd
	are below on all	1 0 7 61 300.			then monthly thereafterTo ens	i i
		1 . 1 . 1 . 1			future compliance, the IDT tea	i i
	_	n dated 4/22/13: "I was			will meet to discuss which clier	nts
		op because [client A]'s			have medical conditions that	
	blood sugar was	low. Upon arrival I			require regular monitoring. A process will then be put in place	ng
	found her to be a	lert and oriented to the			to determine how these	~
	situation. [Healt	h Safety Tech name]			conditions will be monitored, h	ow
	_	ig her take sips of pop.			often, and when they will be	
		HST name] was helping			reviewed by the Nurse. This	
					process will then be placed int	i i
		blood sugar. [Client A]			client specific risk plans to ens	
	had no complain	ts of dizziness. She was			that appropriate medical care i	s

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		15G040	B. WIN			05/16/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R				
ADC OF	NODTUMEST IND	MANA INC. THE			53RD AVE	
ARC OF	NORTHWEST IND	MANA INC, THE		GARY,	IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	not cold or clam	my. [Client A] stated			given to all clients.6/5/13 This	
		he was fine. Blood sugar			facility was not cited at W240)
	^	was allowed to leave			The Community Services Nurs	
					in conjunction with the Service	
		lient A] then sat at a table			Coordinator will revise this clie	
	_	jello and began to eat."			Health risk plan. The Commu	
	No further docu	mentation was submitted			Services Nurse will train all sta	ап
	for review to inc	dicate client A's physician			on the plan; any new staff	l ho
		regards to this nursing			working with the consumer will trained prior to being assigned	
	notation.	- 0			the client. Nursing staff will	
	notation.				observe meal time, med	
		1 . 1 . 1 . 1 . 1 . 1			administration, documentation	
	-Nursing notation				review of the MAR, blood suga	
	"Workshop repo	orted abnormal behaviors,			readings and her journal, risk	
	confusion noted	. BS (blood sugar) at			plans, signs and symptoms of	
	11:20 was 20. N	Nurse at workshop			hypoglycemia and hyperglyce	mia
		iving client a soda pop at			for one month and retrain as	
					needed. If the client's blood su	•
		ontacted [Doctor name]			is under 60, staff will give 4oz	
	_	g. BS reading at 11:50			orange juice or 4oz of pop or 1	l
	A.M. 166. EM	Ts (Emergency Medical			cup of milk. If blood sugar is	
	Techs) arrived t	o transport to ER, resident			greater than 250 mg/dl, the cli will receive Amaryl 2mg tab @	
	refused ER. Re	sident aware of place,			HS. If blood sugar is greater the	
	time and self N	To confusion noted.			400 mg/dl, staff will call 911 th	
		Professional (DSP) at			notify the Nurse. Staff will fax	
					the MAR daily so that the	
	U 1	ructed to monitor BS			Community Services Nurse ca	ın
	_	20, 52 juice given. At			review Client A's blood sugar	
	9:15 102, 7:00 A	A.M., before Amaryl 2 mg			readings on a daily basis by	
	(milligram) dose	e BS read at 97. At			6/15/13. The Community Serv	ices
	workshop 10 Al	M 208, MD notified. BS			Nurse will review these blood	
	*				sugars and make contact with	
	at 3:31 166. MD orders to discontinue Amaryl at HS (bedtime). Will continue to				Client A's physician as necess	sary.
		ocumie). win continue to			The Nurse will document any	
	monitor."				Recommendations made by the client's physician in the client's	
] <u>.</u>				medical file. The Nurse will th	
	-	ient A's day program			email, call, and fax a memo to	
	blood glucose re	eadings was made on			group home detailing the Doct	
	5/10/13 at 4:30	P.M Review of client			recommendations or changes	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	TED
		15G040	A. BUII B. WIN			05/16/2	013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			53RD AVE		
ARC OF	NORTHWEST IND	IANA INC. THE			IN 46410		
					114 404 10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	•	+	DATE
	J 1 C	blood glucose readings			the risk plan. The Nurse will the		
	indicated: "Med	lication Administration			continue to review blood sugar readings on a daily basis to		
	Record dated Ap	oril 2013 and May 2013			determine if the Doctor's		
	[Client A] check BS before lunch11:00				recommendations were effecti	ve.	
	A.M. 4/1-34, 4/2	2-39, 4/3-20, 4/4-185,			In the event an MAR is not		
	· ·	1/9-34, 4/10-21, 4/11-54,			received, the Community		
	4/12-52, 4/15-105, 4/16-86, 4/17-40,				Services Nurse will contact the		
	· ·	05, 4/22-32, 4/23-53,			Area Manager to follow up with		
	· ·				staff. Additionally a Journal wil implemented by 6/15/13 which		
	4/24-64, 4/25-90	,			to include blood sugar reading		
	· ·	, 5/2-23, 5/3-78, 5/6-20,			and interventions, intake and	,	
	· ·	5, 5/9-43, 5/10-72." No			applicable behavioral		
	documentation v	vas available for review			observations. The Community	,	
	to indicate the fa	cility's nursing services			Services Nurse will review this		
	monitored client	A's blood glucose levels			journal weekly. The Director of		
	or contacted her	physician in regards to			Health Services will monitor th		
	her readings.				the nursing staff is receiving the information in a timely manner		
	nor roudings.				through weekly audits of the		
	An interview wi	th the nurse was			information for three months a	nd	
		10/13 at 4:45 P.M The			then monthly thereafter To ens	sure	
	nurse indicated t				future compliance, the IDT tea		
					will meet to discuss which clie	nts	
		vailable for review to			have medical conditions that		
		lity's nursing services			require regular monitoring. A process will then be put in place	_	
		A's blood glucose			to determine how these	, c	
	readings. The nu	urse further indicated			conditions will be monitored, h	ow	
	there was no doo	cumentation to indicate			often, and when they will be		
	client A's physic	ian was contacted in			reviewed by the Nurse. This		
	regards to her lo	w blood glucose readings.			process will then be placed int		
					client specific risk plans to ens		
	This deficiency was	s cited on 3/15/13. The facility			that appropriate medical care i given to all clients. 6/11/13If th		
	_	a systemic plan of correction			client's blood sugar is under 6		
	to prevent recurrence	ce.			over 400, the staff is to contact		
					the Community Services Nurse		
	9-3-6(a)				by phone. If outside of normal		
					business hours staff will utilize	the	
					nurse on call phone. The		
			1				

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	A. BUILDING	00	COMPLETED 05/16/2013			
	PROVIDER OR SUPPLIE	R	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				community services nurse in conjunction with the service coordinator will revise this clied Health risk plan. The community service nurse will train all staff the plan; any new staff workin with the consumer will be train prior to being assigned to the client. The community service nurse will also train on the rist plans annually. This training involve modeling, and return demonstrations of all skills required to implement the plate The Nurse will document any Recommendations made by the client's physician in the client's physician in the client's physician in the client's physician in the client's email, call, and or fax a memorate group home detailing the Doctor's recommendations or changes to the risk plan. Any changes to documentation with faxed back to the nurse for confirmation of accuracy. Training forms will be utilized require staff signature to verificate their understanding, any significant changes will be addressed via the method identified above. The Nurse with the continue to review blood sugar readings on a daily bas determine if the Doctor's recommendations were effective.	inity if on ing ined es k will in. ithe is nen to to in ithe in ithe is in ithe ithe in ithe ithe ithe ithe ithe ithe ithe ithe			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G040	B. WIN	G		05/16/	2013
	ROVIDER OR SUPPLIER			300 W 5	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W000336	clients certified as care plan, a revie which must be on	ICES must include, for those s not needing a medical w of their health status a quarterly or more pending on client need.	W0	00336	Quarterly Nursing Assessments was completed on 3/25/13 however it was misfiled. This document has been located and returned to the client file. To ensure future compliance the quarterly physical assessment was revised 4/13 as was the tracking system for these assessments. The Director of Health Services will audit these tracking sheets on a monthly basis to ensure client B and all other clients receive a quarterly assessment. In addition to ensuring that the quarterly physical assessments are appropriately filed, the Service Coordinator will review all clients' master files monthly for three months and then periodically thereafter.	5	05/30/2013
	1 of 2 sampled c facility's nursing conduct quarterly	review and interview for lients (client B), the services failed to y nursing assessments of status and medical needs.					
	Findings include	:					
	A review of clier conducted at the	nt B's record was administrative office on					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00 COMPI			
15G040			B. WING			05/16/2013		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ADO OF NORTHWEST INDIANA INC. THE				300 W 53RD AVE GARY, IN 46410				
ARC OF NORTHWEST INDIANA INC, THE								
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
IAG	5/8/13 at 12:15 P.M Client B's record			IAG	BATE			
	indicated "Nursing Quarterly"							
	assessments on 10/17/12, 7/3/12, and							
	4/12/12. No Nursing Quarterly was available for review after 10/17/12.							
	Client B's 7/19/12 Individual Support							
	**							
	Plan (ISP) indicated client B's diagnoses							
	included, but were not limited to,							
	Osteoarthritis knees and Hips, Prader							
	Willi Syndrome, Seizure Disorder, and							
	Anxiety.							
	An internion with the many area							
	An interview with the nurse was							
	conducted on 5/10/13 at 4:25 P.M. The							
	nurse indicated no nursing quarterly							
	assessment of client B's healthcare needs							
	was available for review.							
	m: 1 g : 24542							
	This deficiency was cited on 3/15/13.							
	The facility failed to implement a							
	systemic plan of correction to prevent							
	recurrence.							
	9-3-6(a)							
W009999	W009999							
			W0	09999	No tag is cited.		05/30/2013	

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